

S E C T I O N

# 9

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## **Ambulatory care**

**Physicians**

**Hospital outpatient services**

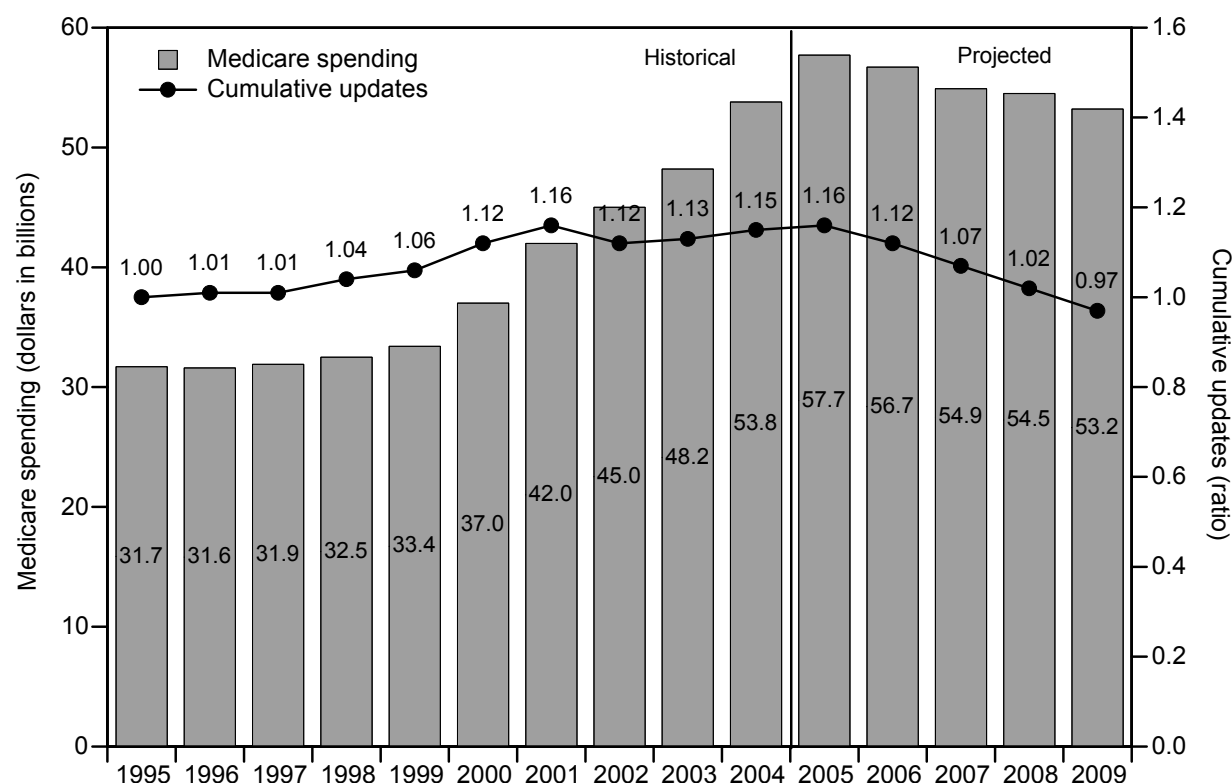
**Ambulatory surgical centers**

**Imaging services**

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**Chart 9-1. FFS Medicare spending and payment update for physician services, 1995–2009**

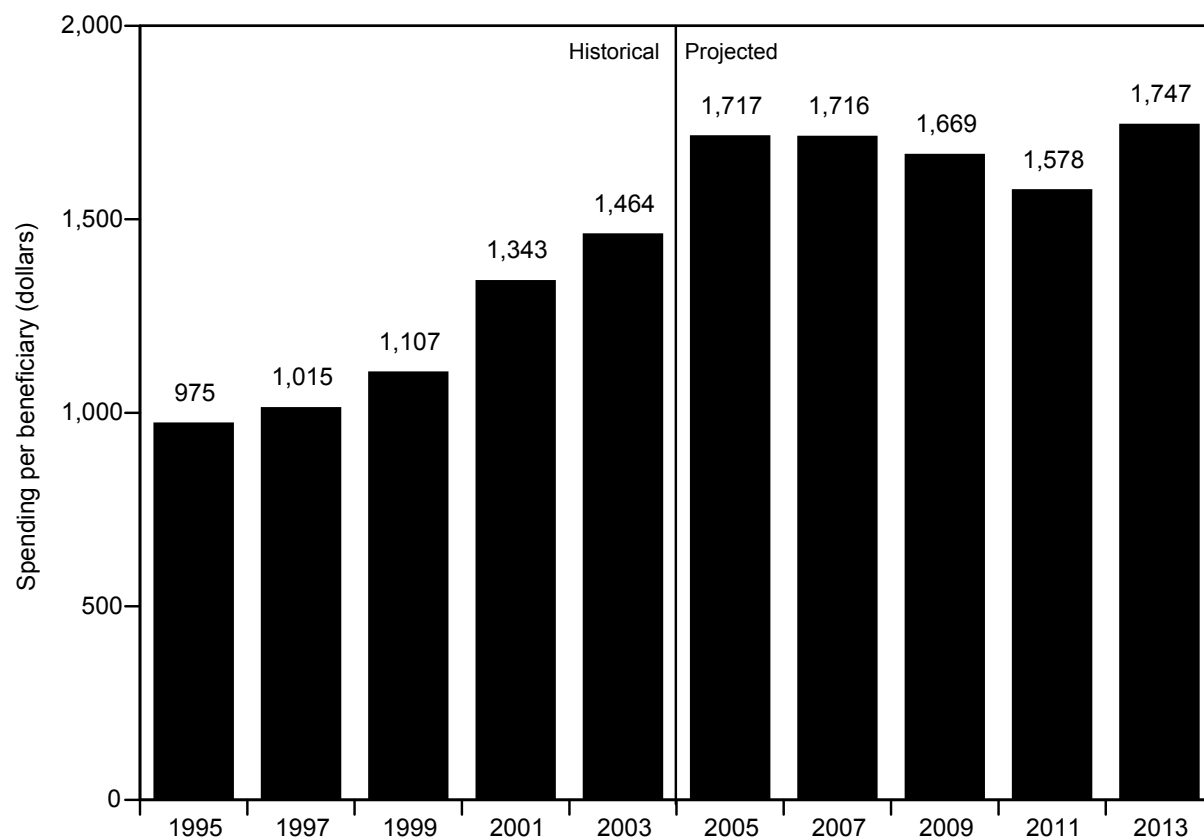


Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: 2005 annual report of the Boards of Trustees of the Medicare trust funds.

- Between 1995 and 1999, Medicare spending on physician services was relatively flat. More rapid growth occurred between 1999 and 2004—averaging 10 percent annually.
- The sustainable growth rate system (SGR) requires that future payment increases for physician services be adjusted for past actual physician spending relative to a target spending level. To avoid reductions in 2004 and 2005 physician fee schedule rates due to the SGR, the Medicare Modernization Act established minimum payment updates for physician services of 1.5 percent for 2004 and 2005. Under current law, payments for physician services are slated to decline about 5 percent for seven consecutive years, beginning in 2006.
- Congressional testimony by the Chairman of MedPAC on physician payments and the SGR is available at [http://www.medpac.gov/publications/congressional\\_testimony/050504\\_SGRTestimony\\_EC.pdf](http://www.medpac.gov/publications/congressional_testimony/050504_SGRTestimony_EC.pdf).
- A full copy of the Trustees report is available at <http://cms.hhs.gov/publications/trusteesreport/default.asp>.

**Chart 9-2. Medicare spending per FFS beneficiary on physician services, 1995–2013**



Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: 2005 annual report of the Boards of Trustees of the Medicare trust funds.

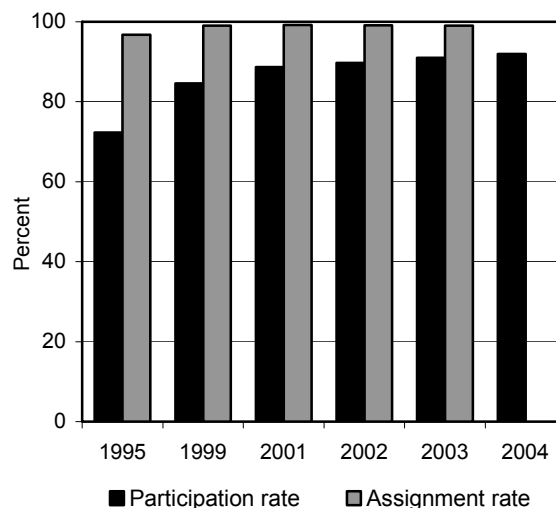
- Fee-for-service (FFS) physician spending per beneficiary has increased annually since 1995 and is expected to continue increasing through 2006.
- Under current law, FFS Medicare payments for physician services per beneficiary are projected to decline after 2006 because of scheduled negative payment updates. The volume of physician services per beneficiary, however, is expected to continue to grow.
- A full copy of the Trustees report is available at <http://cms.hhs.gov/publications/trusteesreport/default.asp>.
- Additional information on Medicare payment for physician services can be found in Chapter 3 of MedPAC's March 2005 Report to the Congress, available at [http://www.medpac.gov/publications/congressional\\_reports/Mar05\\_Ch03.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_Ch03.pdf).

**Chart 9-3. The supply of physicians who furnish services to beneficiaries has increased**

Year	Number of physicians	Number of beneficiaries enrolled in Part B (millions)	Physicians per 1,000 beneficiaries
1999	432,355	37.022	11.7
2000	444,187	37.315	11.9
2001	457,292	37.657	12.1
2002	466,299	37.946	12.3
2003	470,213	38.364	12.3

Note: Calculations include physicians (allopathic and osteopathic) treating at least 15 different beneficiaries in a given year. Nurse practitioners, physician assistants, psychologists, and other health care professionals are not included in these calculations. The beneficiary count includes those in FFS and Medicare Advantage, on the assumption that physicians are providing services to both types of beneficiaries.

Source: MedPAC analysis of Health Care Information System, 1999–2003 from CMS.



Note: Participation rate is the percentage of physicians and nonphysician providers signing Medicare participation agreements. Assignment rate is the percentage of allowed charges paid on assignment. The assignment rate for 2004 is not shown; it requires calculations from claims not yet available.

Source: Ways and Means Green Book (2004), unpublished CMS data, and MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

- The number of physicians providing services to beneficiaries has kept pace with growth in the beneficiary population. From 1999 to 2003, the number of physicians who regularly saw Medicare patients grew by 8.8 percent, but Medicare Part B enrollment grew by only 3.6 percent. This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 11.7 to 12.3.
- A 2003 General Accounting Office report stated that between 1991 and 2001, the number of physicians in the United States increased by 26 percent—twice the rate of total population growth.
- The participation rate—that is, the percentage of physicians who can bill Medicare and who agree to accept assignment on all claims for payment during a year—has risen steadily over the past decade, reaching 92 percent in 2004.
- When physicians accept assignment, they accept Medicare’s fee schedule amount as the service’s full charge (of which 20 percent is beneficiary coinsurance). In 2003, 99 percent of allowed charges for physician services were assigned.
- Additional information and analysis related to this topic can be found in Chapter 2B of MedPAC’s March 2005 Report to the Congress, available at [http://www.medpac.gov/publications/congressional\\_reports/Mar05\\_Ch02b.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02b.pdf).

**Chart 9-4. Spending growth varies by type of service, 2003–2004**

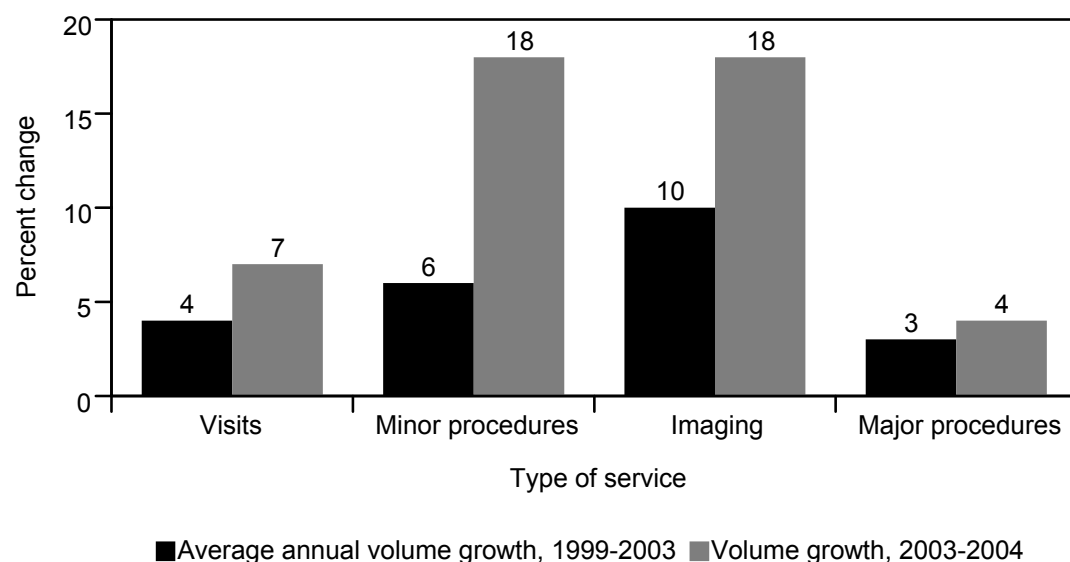
Types of services	Percent of spending	Spending increase
Visits	38%	11%
Minor procedures	20	22
Imaging	14	22
Laboratory and other tests	12	17
Part B drugs	10	17
Major procedures	6	8
Other	1	13
Total	100	15

Note: In both columns of numbers, percentages may not necessarily add to the total, due to rounding. The total spending increase is a weighted average, so the spending increases by type of service do not sum to the total.

Source: Kuhn, H.B., CMS, Letter to MedPAC, March 31, 2005, and unpublished data from CMS.

- Physician services can be classified by type of service. The visit category consists primarily of office visits but also includes consultations and visits to patients in facility settings. Examples of major procedures include open heart surgery, joint replacement, and back surgery. Minor procedures include colonoscopy, knee arthroscopy, and various eye procedures, such as cataract surgery. Tests range from laboratory specimen analysis to electrocardiograms and cardiovascular stress tests. Imaging includes x-rays of the chest, the musculoskeletal system, and other parts of the body as well as more advanced procedures, such as computed tomography and magnetic resonance imaging (MRI). Part B drugs consist of covered drugs furnished in physician offices.
- Growth in spending for physician services varies by type of service. Between 2003 and 2004, growth was highest for imaging and minor procedures.
- CMS attributes much of the increase in minor procedures to spending for chemotherapy administration and physical therapy. The increase in spending for chemotherapy administration is at least partly due to an increase in payments for the services required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
- CMS attributes most of the overall rise in spending to growth in the volume of services. Growth in the number of beneficiaries accounts for only a small fraction of the increase, and CMS estimates that legislative changes—namely, provisions in the MMA—account for only about one-fifth of the increase.

**Chart 9-5. Volume grew more rapidly in 2004 than in previous years**



Note: For minor procedures, volume growth from 2003 to 2004 includes changes in the structure of payments for chemotherapy administration.

Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries, 1999-2004.

- Growth in the volume of physician services in 2004 was considerably higher than it was from 1999 to 2003. The biggest difference (12 percentage points) was in minor procedures, which increased 18 percent in 2004 compared with 6 percent average annual growth from 1999 to 2003. Growth in the volume of imaging was also much higher in 2004: 18 percent in 2004 compared with 10 percent annually from 1999 to 2003.
- Some of the increase may be due to factors often cited as reasons for growth in spending and use of services: technological innovations, defensive medicine, direct-to-consumer advertising, shifts in the site of care, and adherence to clinical guidelines that call for more intensive treatment of chronic illness. However, these factors are not likely the whole story because all of them have been at work for at least several years.
- It is not clear whether volume growth contributes to better health outcomes.
- One consequence of volume and spending growth is that CMS now expects the monthly Medicare Part B premium to rise higher than previously expected.
- For more information on this topic, see MedPAC's December 2004 report on Growth in Volume of Physician Services, available at [http://www.medpac.gov/publications/congressional\\_reports/Dec04\\_PhysVolume.pdf](http://www.medpac.gov/publications/congressional_reports/Dec04_PhysVolume.pdf).

**Chart 9-6. Medicare Economic Index input categories, weights, and projected price changes for 2006**

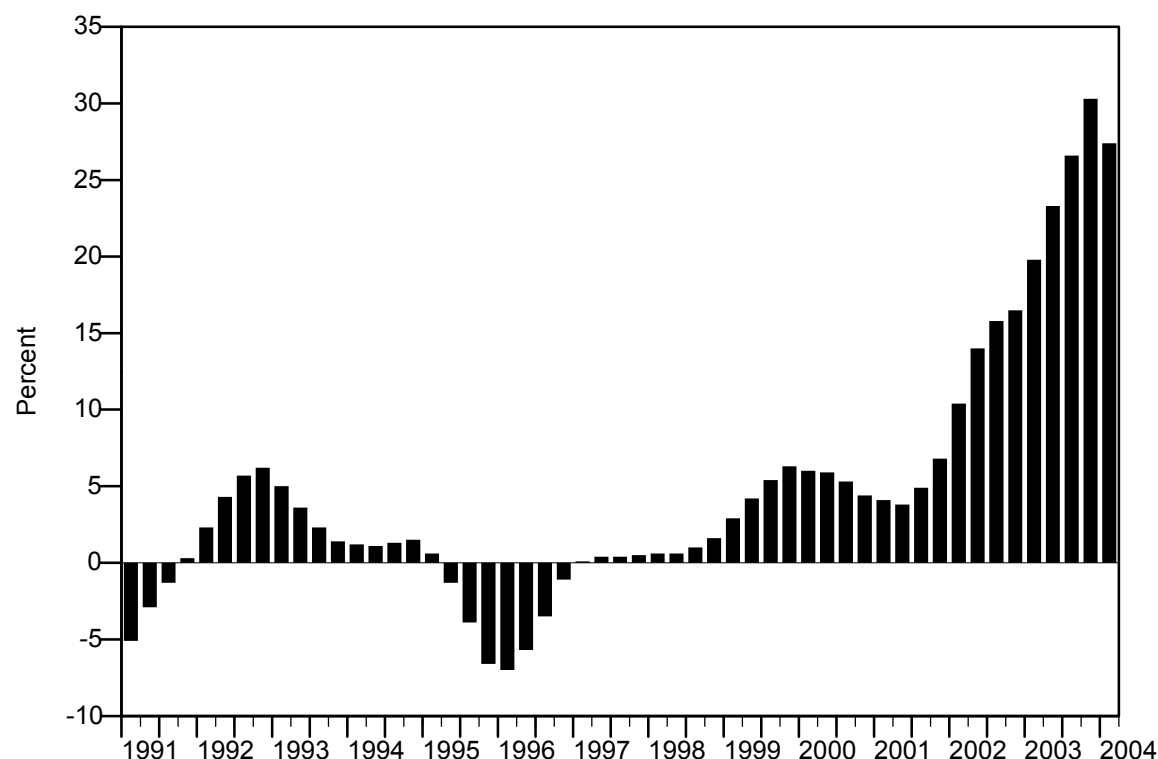
Input component	Category weight	Price changes for 2006
<b>Total</b>	<b>100.0%</b>	<b>3.5%</b>
<b>Physician work</b>	<b>52.5</b>	<b>3.4</b>
Wages and salaries	42.7	3.2
Fringe benefits (nonwage compensation)	9.7	4.2
<b>Physician practice expense</b>	<b>47.5</b>	<b>3.6</b>
Nonphysician employee compensation:	18.7	3.5
Wages and salaries	13.8	3.2
Fringe benefits (nonwage compensation)	4.8	4.3
Office expense	12.2	2.0
Professional liability insurance	3.9	8.4
Medical equipment	2.1	1.6
Drugs and supplies:	4.3	3.0
Pharmaceuticals	2.3	3.7
Medical materials and supplies	2.0	2.2
Other professional expense	6.4	2.1

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not sum to 100% due to rounding.

Source: Unpublished, fourth-quarter 2006 estimates from CMS, dated September 21, 2004.

- An important factor in determining the payment update for physician services is the projected change in input prices for physician services as measured by the Medicare Economic Index (MEI). The MEI is a weighted average of price changes for physician time and effort (i.e., work) and practice expense.
- CMS projects that input prices for physician work will increase 3.5 percent in 2006, based on increases of 3.2 percent in wages and salaries and 4.2 percent in nonwage compensation. Practice expenses are projected to increase 3.6 percent. This projection primarily reflects a 3.5 percent increase in nonphysician employee compensation and a 2.0 percent increase in office expenses.
- Professional liability insurance has the largest projected price change, 8.4 percent.
- Additional information and analysis related to this topic can be found in Chapter 2B of the MedPAC March 2005 Report to the Congress, available at [http://www.medpac.gov/publications/congressional\\_reports/Mar05\\_Ch02b.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02b.pdf).

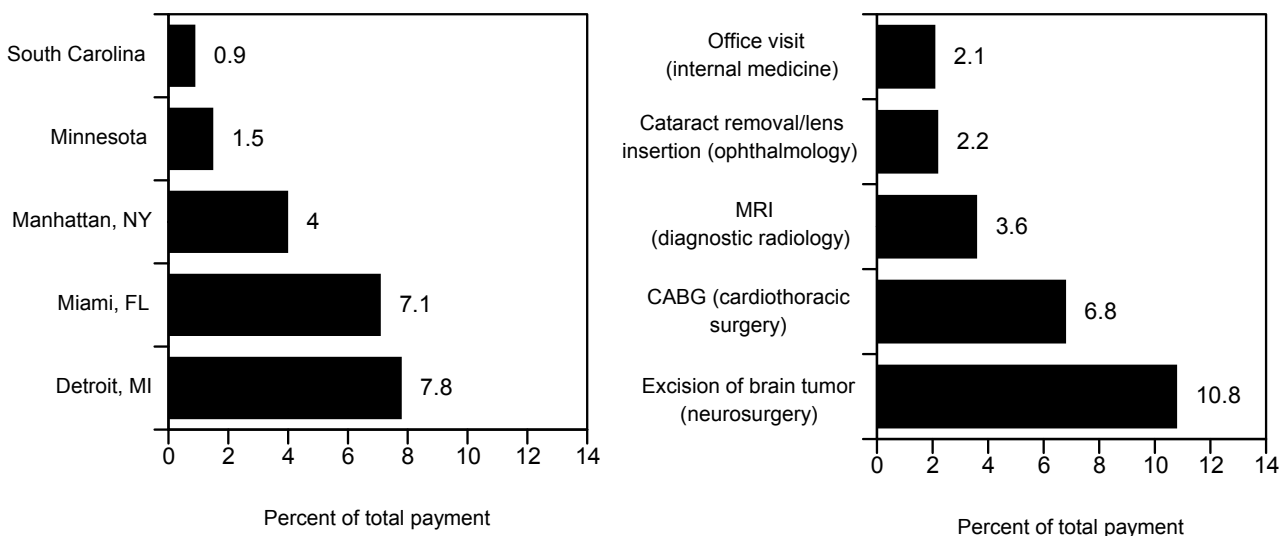
**Chart 9-7. Quarterly changes in professional liability insurance premiums, 1991–2004**



Source: Unpublished CMS data.

- Historically, the professional liability insurance (PLI) component of the Medicare Economic Index followed a strong cyclical pattern, illustrated by the changes in PLI premiums from 1990 to 2001. The cycle is generally characterized by periods of low premiums, perhaps when insurers are building market share, and high premiums, perhaps when insurers are building reserves.
- Since 2001, changes in PLI premiums have departed from this cyclical pattern. The increase in the fourth quarter of 2003, estimated at 30.3 percent, was the highest in over a decade.

**Chart 9-8. PLI payments vary by locality and service, as a percentage of total payments under the Medicare fee schedule, 2002**

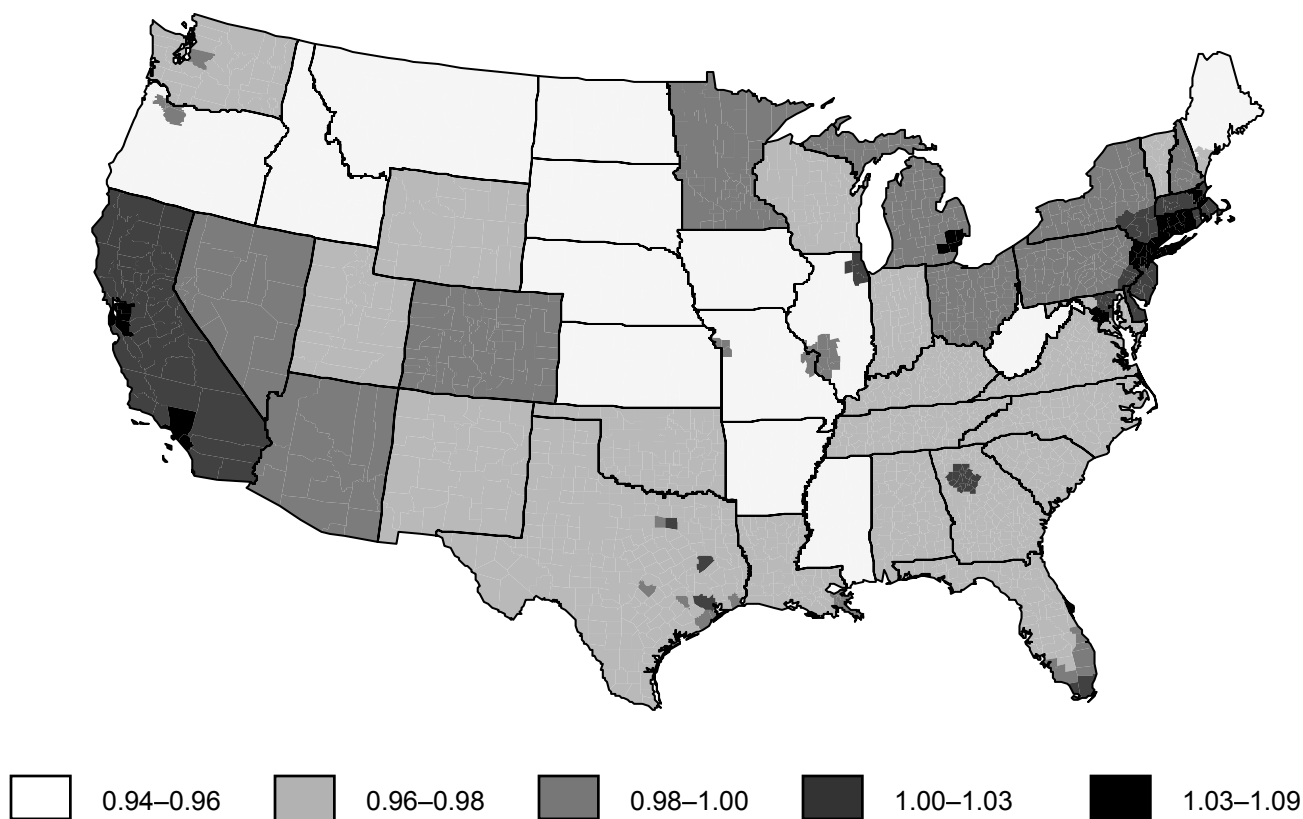


Note: PLI (professional liability insurance), CABG (coronary artery bypass graft), MRI (magnetic resonance imaging). PLI payments for services are national averages.

Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries in 2002.

- Medicare accounts for physicians' costs for professional liability insurance (PLI) in three ways. One way is through the Medicare Economic Index (MEI), which is used to adjust payments equally to account for PLI costs across all physicians serving Medicare beneficiaries. The other two ways are through the physician fee schedule, which assigns relative value units (RVUs) to services and geographic practice costs indexes (GPCIs) to areas of the country. These two components of the fee schedule allow Medicare payments to account for PLI differentially—by service and by geographic area—based on PLI premium differences.
- The fee schedule's RVUs designate higher payments for services furnished by neurosurgeons and cardiothoracic surgeons, who bear higher PLI premiums. Similarly, the fee schedule's GPCIs adjust payments to physicians who practice in geographic areas with high PLI premiums, such as Detroit, Michigan. Given both of these factors, over 20 percent of Medicare's payments to a Detroit neurosurgeon under the fee schedule can be attributable to PLI, if a fairly high proportion of the neurosurgeon's practice consists of major procedures.
- Additional information and analysis related to this topic can be found in Chapter 2B of the MedPAC March 2005 Report to the Congress, available at [http://www.medpac.gov/publications/congressional\\_reports/Mar05\\_Ch02b.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02b.pdf).

**Chart 9-9. Work GPCI before the MMA established a floor of 1.00**

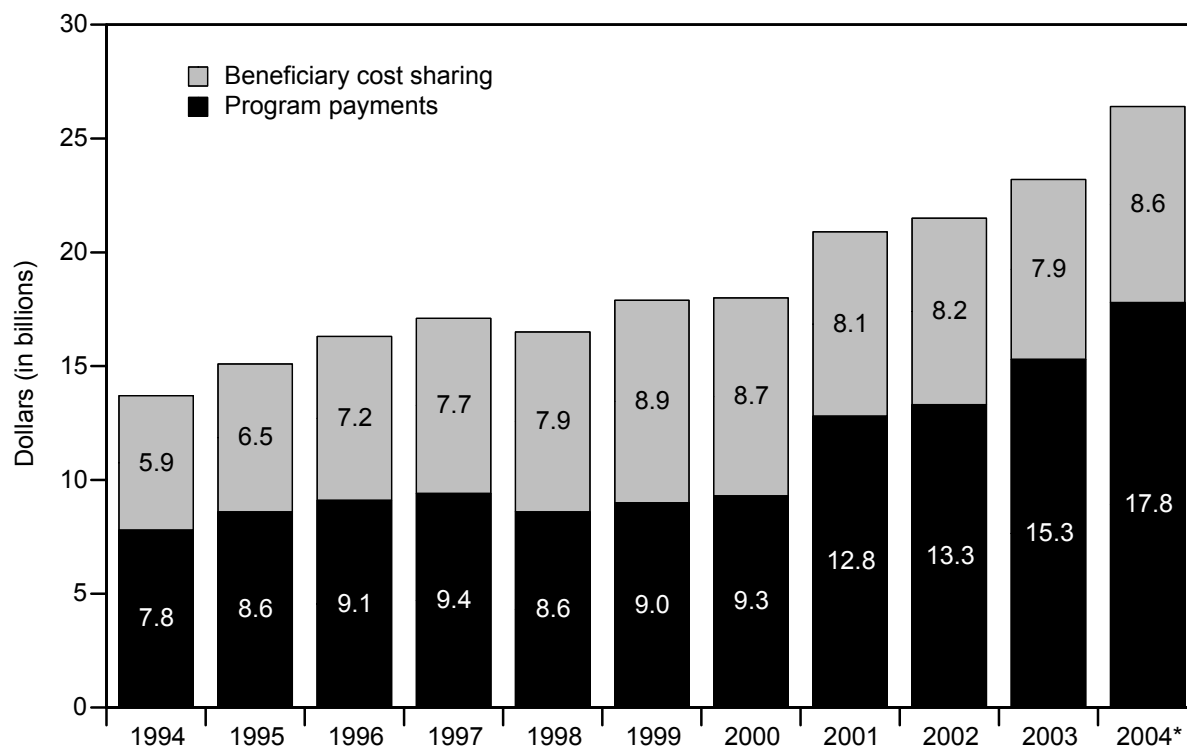


Note: GPCI (geographic practice cost index), MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003).

Source: Geographic practice cost index from CMS.

- Under Medicare's physician fee schedule, geographic practice cost indexes (GPCIs) adjust payment rates to account for differences in the price of inputs used in furnishing physician services. There are three GPCIs, one corresponding to each component of the relative value scale: physician work, practice expense, and professional liability insurance (PLI). The three GPCIs are applied to determine rates for each of 89 payment areas.
- Prior to the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the work GPCI ranged from 0.94 to 1.09, as shown in the map. The MMA temporarily reduced this variation by establishing a three-year floor for the work GPCI of 1.00.
- The work GPCI floor will expire on December 31, 2006, at which point it is expected that work GPCIs will again vary widely across the 89 payment areas nationwide.
- Additional information on the GPCIs can be found in a MedPAC issue brief available at [http://www.medpac.gov/publications/other\\_reports/Aug03\\_GPCI\\_2pgrKH.pdf](http://www.medpac.gov/publications/other_reports/Aug03_GPCI_2pgrKH.pdf).

**Chart 9-10. Spending on all hospital outpatient services, 1994–2004**



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (such as ambulance services or durable medical equipment) or those paid on a cost basis (such as organ acquisition or flu vaccines). They do not include payments for clinical laboratory services.  
\* Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services almost doubled from calendar year 1994 to 2004. Growth was fast in the mid 1990s, slowed in the late 1990s, and accelerated again in 2001. The Office of the Actuary projects continued growth in total spending, averaging 7.9 percent per year from 2002 to 2007.
- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent about 90 percent of spending on all hospital outpatient services (excluding clinical laboratory services, which is paid under a fee schedule).
- In 2001, the first full year of the outpatient PPS, spending under the PPS was \$19.2 billion, including \$11.4 billion by the program and \$7.7 billion in beneficiary cost sharing. By 2004, spending under the outpatient PPS is expected to rise to \$24.0 billion (\$15.9 billion program spending; \$8.1 billion beneficiary copayments). The outpatient PPS accounted for about 5 percent of total Medicare spending by the program in 2004.
- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 34 percent in 2004. Chart 9-14 provides more detail on coinsurance.

## Chart 9-11. Most hospitals provide outpatient services

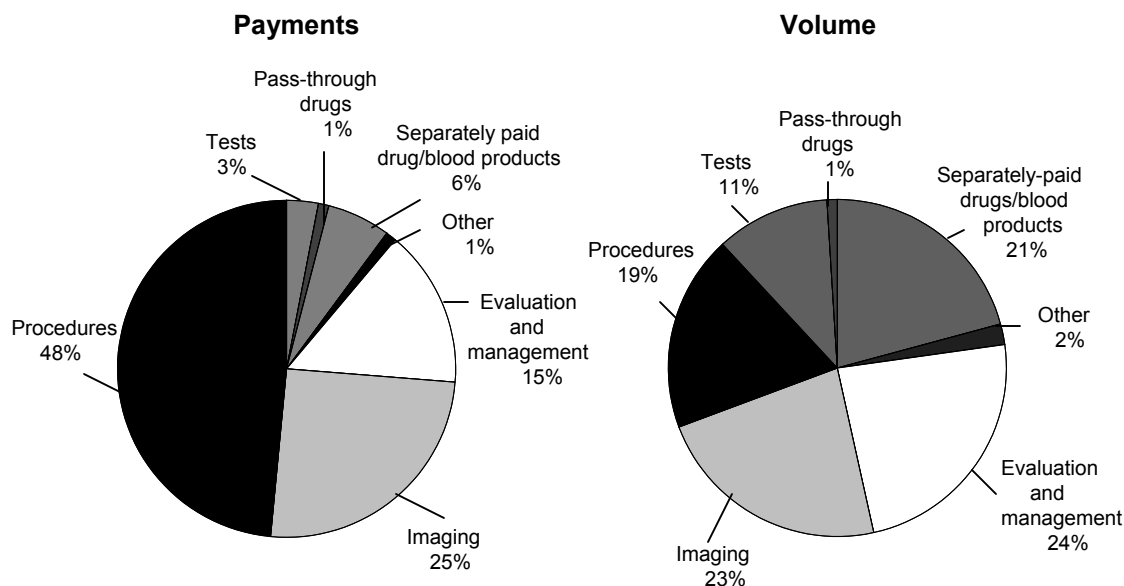
Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
1991	5,191	92%	79%	91%
1997	4,976	93	81	92
2001	4,347	94	84	93
2002	4,210	94	84	93
2003	4,079	94	86	93

Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- While the number of hospitals has fallen over the past decade, the percent providing outpatient services, outpatient surgery, and emergency services has grown.
- Almost all hospitals provide outpatient (94 percent) and emergency (93 percent) services. The vast majority (86 percent) provides outpatient surgery.
- The share of hospitals providing outpatient services did not change after the introduction of the outpatient prospective payment system.

**Chart 9-12. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2003**



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing, but do not include transitional corridor payments (see chart 9-15 for further information regarding transitional corridor payments). Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages do not sum to 100 due to rounding.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient PPS claims for 2003 from CMS.

- The volume of services is distributed differently than payments. For example, procedures account for 19 percent of the volume, but 48 percent of the payments.
- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- Almost half of the services provided in hospital outpatient departments are evaluation and management or imaging services.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of spending on services (48 percent), followed by imaging services (25 percent), and evaluation and management (15 percent).
- In 2003, separately paid drugs and blood products accounted for 6 percent of spending.

**Chart 9-13. Hospital outpatient services with the highest Medicare expenditures, 2003**

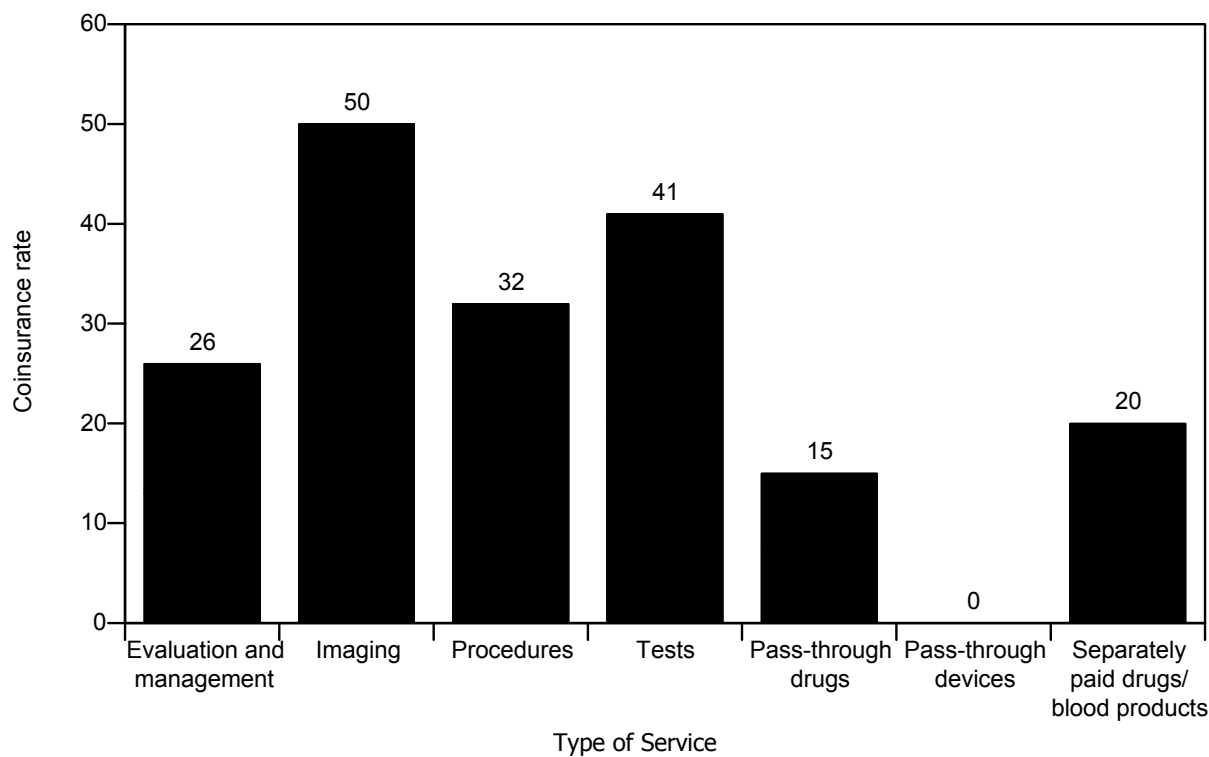
APC	Title	Share of payments
Total		50
0610, 0611, 0612	All emergency visits	8%
0246	Cataract procedures with IOL insert	4
0600, 0601, 0602	All clinic visits	4
0283	Computerized axial tomography (CAT) with contrast material	4
0080	Diagnostic cardiac catheterization	3
0260	Level I plain film except teeth	3
0143	Lower gastrointestinal endoscopy	3
0301	Level II radiation therapy	3
0332	CAT and computerized angiography without contrast material	3
0336	Magnetic resonance imaging (MRI) and magnetic resonance angiography without contrast	2
0337	MRI and magnetic resonance angiography without contrast material followed by contrast material	2
0141	Upper gastrointestinal procedures	2
0120	Infusion therapy except chemotherapy	1
0280	Level III angiography and venography except extremity	1
0286	Myocardial scans	1
0325	Group psychotherapy	1
0333	Computerized axial tomography and computerized angio w/o contrast material followed by contrast	1
0267	Level III diagnostic ultrasound except vascular	1
0131	Level II laparoscopy	1
0154	Hernia/hydrocele procedures	1

Note: APC (ambulatory payment classification), IOL (intraocular lens). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of the 100 percent analytic file of outpatient prospective payment system claims for calendar year 2003.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

**Chart 9-14. Medicare coinsurance rates, by type of hospital outpatient service, 2003**



**Note:** Services were grouped into categories of evaluation and management, procedures, imaging, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicators.

**Source:** MedPAC analysis of 100 percent special analytic file of 2003 outpatient prospective payment system claims and payment rates.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payment over time.
- In adopting the outpatient prospective payment system, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time. The objective is for all cost sharing to move to 20 percent.
- The coinsurance rate is different for each service. Some services, such as imaging, have very high rates of coinsurance—50 percent. Other services, such as clinic visits, have coinsurance rates of 20 percent.
- In 2003, the overall coinsurance rate was about 34 percent.

**Chart 9-15. Transitional corridor payments as a share of Medicare hospital outpatient payments, 2001–2003**

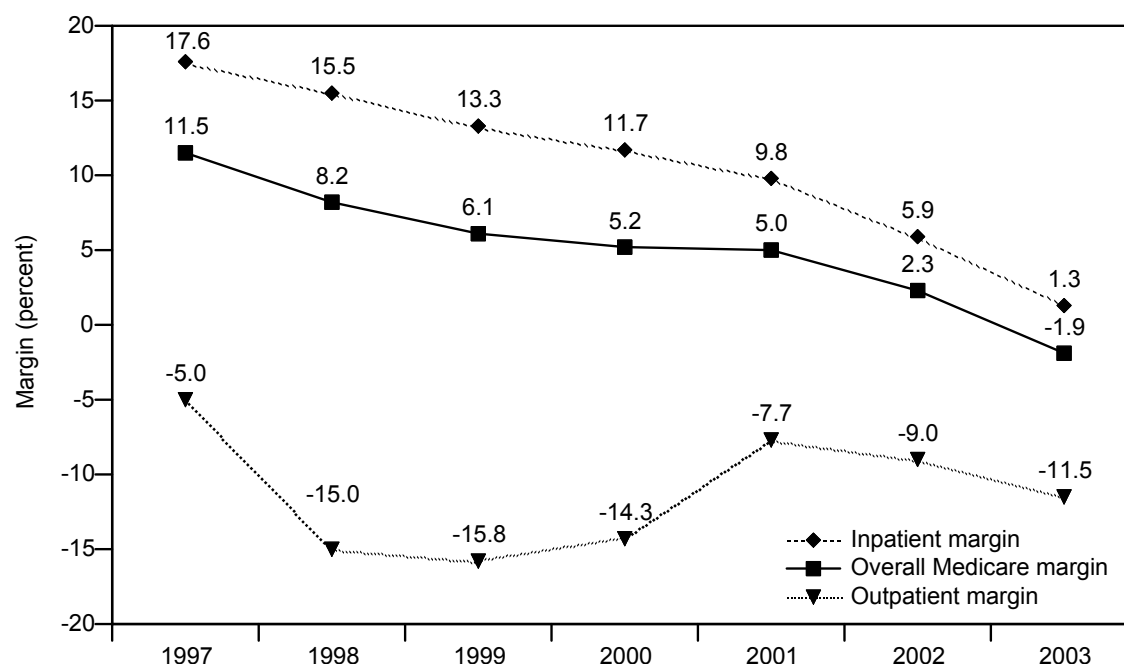
Hospital group	2001		2002		2003	
	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors
All hospitals	3,673	2.3	3,578	2.6	3,404	2.4
Urban	2,531	2.2%	2,475	2.4%	2,352	1.9%
Rural ≤ 100 beds	889	4.5	861	6.2	815	8.1
Rural >100 beds	252	0.8	241	1.4	220	1.7
Major teaching	288	5.2	284	5.2	259	3.4
Other teaching	794	1.2	776	1.6	737	1.5
Nonteaching	2,590	1.9	2,517	2.3	2,392	2.6

Note: A small number of hospitals could not be classified due to missing data.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- When Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000, Medicare moved from paying hospitals based on their costs to a payment schedule based on average (median) costs for all hospitals.
- Recognizing that some hospitals might receive lower payments under the outpatient PPS than they had under the earlier system, the Congress included a transition mechanism, called transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS. To provide incentives for efficiency, Medicare did not compensate the full difference, except for rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals.
- Transitional corridor payments represented 2.3 percent of total outpatient PPS payments in 2001, growing to 2.6 percent in 2002, then declining to 2.4 percent in 2003.
- In 2003, rural hospitals with 100 or fewer beds received 8.1 percent of their payments from transitional corridor payments.
- Major teaching hospitals also reported greater shares of transitional corridor payments, receiving over 5 percent of their payments from this source in 2001 and 2002, and 3.4 percent in 2003.

**Chart 9-16. Medicare hospital outpatient, inpatient, and overall Medicare margins, 1997–2003**



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system), skilled nursing facilities, and home health services, as well as graduate medical education.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2003, while the aggregate margin was –11.5 percent, 25 percent of hospitals had margins of –22.1 percent or lower, and 25 percent had margins of –3.8 percent or higher.
- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. To avoid these allocation problems, MedPAC generally uses the overall Medicare margin to assess overall payment adequacy for hospital services.
- The dip in outpatient margins in 1998 is due primarily to the elimination of inadvertent overpayments. These overpayments resulted from an error in payment formulas for certain services that did not adequately account for beneficiary coinsurance when determining program payments.
- The improvement in outpatient margins from 1999 to 2001 is consistent with policies implemented under the outpatient prospective payment system that increased payments. Margins declined somewhat from 2001 to 2003.

**Chart 9-17. Medicare-certified ASCs increased over 50 percent, 1998–2004**

	1998	1999	2000	2001	2002	2003	2004
Medicare payments (billions of dollars)	1.1	1.2	1.4	1.6	1.9	2.2	N/A
Number of centers	2,644	2,786	3,028	3,371	3,597	3,887	4,136
New centers	228	162	295	446	309	365	315
Exiting centers	46	20	53	103	83	75	66
Net percent growth from previous year	7.4%	5.4%	8.7%	11.3%	6.7%	8.1%	6.4%
Percent of all centers that are:							
For profit	94%	94%	94%	94%	95%	95%	96%
Nonprofit	6	6	6	5	5	5	4
Urban	89	89	88	88	87	87	87
Rural	11	11	12	12	13	13	13

Note: ASC (ambulatory surgical center), N/A (not available). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 1998–2004. Payment data from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are distinct entities that only furnish outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare’s conditions of coverage, which specify minimum facility standards.
- The number of Medicare-certified ASCs grew at an average annual rate of 7.7 percent from 1998 through 2004. Each year from 1998 through 2004, an average of 303 new Medicare-certified facilities entered the market, while an average of 64 closed or merged with other facilities.
- The overwhelming majority of Medicare-certified ASCs are for-profit facilities and are located in urban areas.

**Chart 9-18. Over half of most common ambulatory surgical procedures were performed in hospital outpatient departments, 2001**

Procedure category	Share of ambulatory surgical volume, all settings*	Share of volume, by setting		
		Outpatient departments	Physician offices	ASCs
Total	88.1%	53.1%	24.1%	22.8%
Colonoscopy	16.0	70.8	4.3	24.9
Cataract removal and lens insertion	12.5	47.7	0.5	51.8
Minor procedures—musculoskeletal	10.7	48.1	31.1	20.8
Upper gastrointestinal endoscopy	9.5	72.0	4.5	23.5
Cystoscopy	9.0	28.7	63.8	7.5
Ambulatory procedures—skin	7.9	42.4	52.6	5.0
Other ambulatory procedures	7.3	69.8	16.5	13.8
Other eye procedures	6.9	27.5	33.6	39.0
Other minor procedures	5.0	30.1	63.3	6.5
Ambulatory procedures—musculoskeletal	3.4	59.8	17.4	22.9

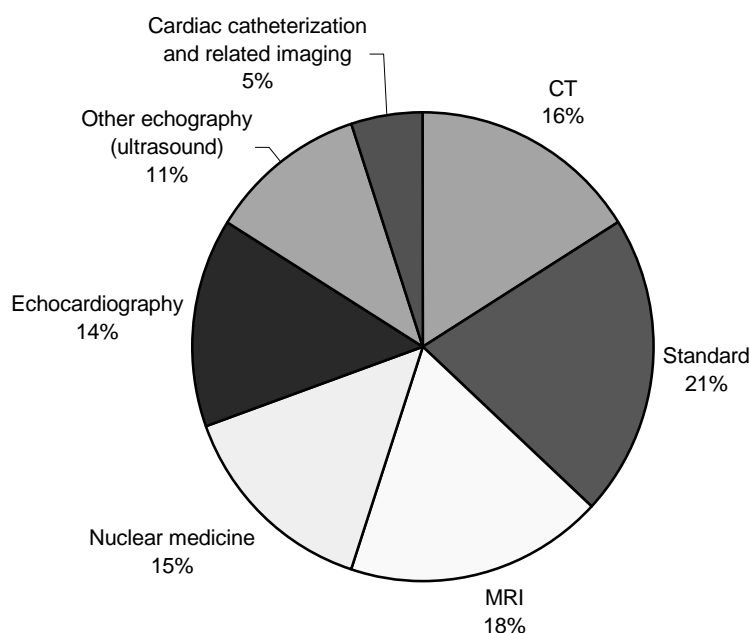
Note: ASC (ambulatory surgical center). Table only includes ambulatory surgical procedures that are on the list of services payable by Medicare when performed in an ASC. Procedure categories are arranged by their share of ambulatory surgical volume across all settings, from highest to lowest. Minor procedures—musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Ambulatory procedures—skin includes skin debridement, excision of lesion, wound repair, and skin graft. Other ambulatory procedures include breast biopsy, nasal polyp excision, abscess drainage, and nerve graft. Other eye procedures includes after-cataract laser surgery. Other minor procedures includes nasal, oral, urological, and nerve procedures. Ambulatory procedures—musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair.

\*All settings includes outpatient departments, physician offices, and ASCs.

Source: MedPAC and RAND analysis of the 5 percent Standard Analytic Files of physician, outpatient department, and ASC claims from CMS, 2001, and the Berenson-Eggers Type of Service classification scheme developed by CMS.

- Outpatient departments account for 71 percent of colonoscopies—the most common ambulatory surgical procedure.
- Over half of cataract removal and lens insertion procedures are provided in ASCs.
- Physician offices account for a majority of cystoscopy procedures, ambulatory procedures—skin, and other minor procedures.

**Chart 9-19. Medicare spending for imaging services, by type of service, 2003**

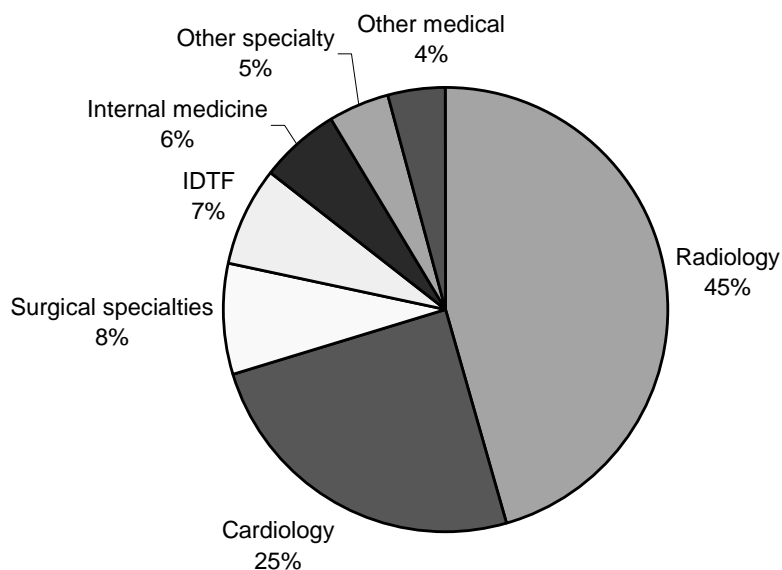


Note: CT (computed tomography), MRI (magnetic resonance imaging). Cardiac catheterization includes placement of the catheter and the related imaging procedure, such as angiogram. Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file, 2003.

- Medicare spending for imaging services paid under the physician fee schedule grew by over 60 percent between 1999 and 2003, from \$5.7 billion to \$9.3 billion.
- The volume and complexity of imaging services grew by 45 percent between 1999 and 2003, more than twice as fast as all physician services (22 percent). These growth rates are adjusted for increases in the number of fee-for-service beneficiaries and changes in payment rates.
- Spending for MRI, CT, and nuclear medicine has grown faster than for other imaging services. Thus, these categories represent an increasing share of total imaging spending. MRI spending grew by 116 percent between 1999 and 2003, nuclear medicine by 104 percent, and CT by 84 percent.

**Chart 9-20. Radiologists received almost half of Medicare payments for imaging services, 2003**



Note: IDTF (independent diagnostic testing facility). Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Total fee schedule imaging spending was \$9.3 billion in 2003. "Other specialty" includes otolaryngology, pain management, osteopathic, physical medicine, nephrology, podiatry, cardiac surgery, oncology, and portable x-ray supplies.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file, 2003.

- Imaging services paid under the physician fee schedule involve two parts: the technical component, which covers the cost of the equipment, supplies, and nonphysician staff, and the professional component, which covers the physician's work in interpreting the study and writing a report. A physician who both performs and interprets the study submits a global bill, which includes the technical and professional components.
- Independent diagnostic testing facilities (IDTFs) are independent of a hospital and physician office and only provide outpatient diagnostic services. Medicare pays for IDTF services under the physician fee schedule at the same rates as services provided in physician offices.
- CMS applies specific rules to IDTFs that do not apply to physician offices that provide diagnostic tests. For example, IDTFs must have supervising physicians who oversee testing quality and nonphysician staff who are licensed or certified. However, enforcement of these standards is not rigorous; after initial enrollment in Medicare, IDTFs are generally not subject to periodic survey and certification.

## Web links. Ambulatory care

### Physicians

- Chapter 2B of the MedPAC March 2005 Report to the Congress provides additional information on physician services.

[http://www.medpac.gov/publications/congressional\\_reports/Mar05\\_Ch02b.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02b.pdf)

- The 2005 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

<http://www.cms.hhs.gov/publications/trusteesreport>

- Congressional testimonies by the Chairman of MedPAC on May 5, 2004 and February 10, 2005, discuss payment for physician services in the Medicare program.

[http://www.medpac.gov/publications/congressional\\_testimony/050504\\_SGRTestimony\\_EC.pdf](http://www.medpac.gov/publications/congressional_testimony/050504_SGRTestimony_EC.pdf)

[http://www.medpac.gov/publications/congressional\\_testimony/021005\\_WM\\_testimony.pdf](http://www.medpac.gov/publications/congressional_testimony/021005_WM_testimony.pdf)

### Hospital outpatient services

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

[http://www.medpac.gov/publications/congressional\\_reports/Mar04\\_Ch3A.pdf](http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf)

- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress.

[http://www.medpac.gov/publications/congressional\\_reports/Mar01%20Ch9.pdf](http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf)

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

[http://www.medpac.gov/publications/congressional\\_reports/Mar03\\_Ch4.pdf](http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf)

### Ambulatory surgical centers

- Chapter 3F of the MedPAC March 2004 Report to the Congress provides additional information on ambulatory surgical centers.

[http://www.medpac.gov/publications/congressional\\_reports/Mar04\\_Ch3F.pdf](http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf)



